EXHIBIT 2

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1017577 5-166-839-0
Step 1 Request Form

UNITED STATES MEDICAL LICENSING EXAMINATION™ (USMLE™)

Step 1 and Step 2 Clinical Knowledge
Applicant's Request for Test Accommodations

You MUST provide supporting documentation verifying your functional impairment.
In order to document your need for accommodation as completely as possible, please attach:

- **Evaluation reports of appropriate professionals printed on letterhead and signed by the evaluator(s)**
- **Primary documentation (report cards, teacher notes, behavioral observations, medical records, lab reports, etc.)**
- **A personal statement describing your disability and it's impact on your daily life and educational functioning. Do not confine your comments to standardized test performance; rather discuss your overall functioning.**
- **Read documentation information on page 4.**

Please note: NBME will acknowledge receipt of your request and audit your request for completeness. Submission of incomplete or illegible request forms and/or insufficient supporting documentation will slow the processing of your request. You may be asked to complete your request in a timely manner by submitting additional documentation.

Information regarding the granting or denial of test accommodations will not be released via telephone. All official communications regarding your request will be made in writing. Should you wish to modify or withdraw a request for test accommodations, please contact Disability Services at 215-590-9509.

Please type or print.

Accommodations are requested for the following Step examination (Use a separate form for each exam):
☑ Step 1 ☐ Step 2 Clinical Knowledge ☐ Step 2 Clinical Skills Year:

Section A: Biographical Information

1. Name: MAHMOOD (Last) MARIA (First) (Middle Initial)
2. Gender: Male (Female)
3. Date of Birth:
4. SS# (if known)
5. USMLE # 5-166-839-0
6. Address: 14717 EXBURY LANE (Street)
   LAUREL (City) MD (State/Province) 20707 (Zip/Postal Code)
   U.S. (Country)
   (Daytime Telephone Number)
   (Alternate Telephone Number)
   (E-mail address)

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Medical School: UNIVERSITY OF ILLINOIS AT CHICAGO COLLEGE OF MEDICINE

(Over)

EXHIBIT
Mahmood 2
LD 11-19-12
PENGAD 800-631-6989

Section B: Nature of Disability

8. Indicate the **nature of the disability** and the year it was first professionally diagnosed (select all that apply):

Sensory Impairments:
- ☐ Hearing Disability
- ☑ Visual Disability 1988

Learning Impairments:
- ☐ Reading Disability
- ☐ Writing Disability
- ☐ Mathematics Disability
- ☐ Other:

Language Impairments:
- ☐ Receptive Language Disorder
- ☐ Expressive Language Disorder
- ☐ Mixed Receptive/Expressive Language Disorder
- ☐ Other:

Medical Impairments:
- ☐ Mobility/Motor
- ☐ Diabetes/Thyroid Dysfunction
- ☐ Epilepsy/Neurological
- ☐ Other:

Mental Health /Executive Function Impairments:
- ☐ Anxiety Disorder
- ☐ Mood Disorder/ Depression
- ☐ Attention Deficit Hyperactivity Disorder
- ☐ Other:

Section C: Accommodations Information

10. What accommodation(s) are you requesting? Accommodation(s) must be appropriate to the disability:

ADDITIONAL TESTING TIME (X2), PAPER EXAM, PERMISSION TO BRING ASSISTIVE DEVICE (MONOCULAR) INTO THE TESTING ROOM.

11. If you are requesting additional testing or break time, please indicate the amount of time requested (circle no more than one per Step).

STEP 1:

- ☐ Additional Break Time over 1 day
- ☐ Additional Break Time over 2 days
- ☐ Additional Testing Time – Time and one-half
- ☑ Additional Testing Time – Double Time
- ☐ Other (please specify):

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(Continued on the next page)

STEP 2:

- ☐ Additional Break Time over 2 days
- ☐ Additional Testing Time - Double Time
- ☐ Additional Testing Time Time and one-half
- ☐ Other (please specify): _____

12. Do you require wheelchair access at the examination facility?

☐ yes ☑ no

If you require an adjustable height table, please indicate the number of inches from the floor:

Section D: Accommodation History

13. Prior classroom or test accommodations that you have received:

A. Standardized Examinations ☑ yes ☐ no

Medical College Admission Test (MCAT):

Month/Year AUGUST / 2002

Accommodation received ADDITIONAL TESTING TIME - DOUBLE TIME

(If extra time, note amount given X2)

Other: SAT

Month/Year NOVEMBER / 1997

Accommodation received ADDITIONAL TESTING TIME

(If extra time, note amount given X2)

B. Medical School ☑ yes ☐ no

Accommodation received ADDITIONAL TESTING TIME - DOUBLE TIME

Date Approved AUGUST, 2004

If yes, have an appropriate official at your medical school complete the Certification of Prior Test Accommodations form.

C. College ☑ yes ☐ no

If yes, accommodations received ADDITIONAL TESTING TIME - DOUBLE TIME

D. Secondary or elementary school ☑ yes ☐ no

If yes, accommodations received ADDITIONAL TESTING TIME

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14. Authorization:

I authorize the National Board of Medical Examiners (NBME) to contact the entities identified in Section D of this request form, and the professionals identified in the documentation I am submitting in connection with it, to obtain any or all of the following: confirmation, clarification, and/or further information. I authorize such entities and professionals to provide NBME with all requested confirmation, clarification, and further information.

Signature: _____ Date: 03/15/07

DO NOT SUBMIT:

- Original documents; keep the original and submit a copy
- Research articles, resumes, curriculum vitas
- Handwritten letters from physicians or evaluators
- Handwritten letters from physicians or evaluators
- Documentation previously submitted to Disability Services
- Documentation previously submitted to your registration entity
- Previous correspondence from Disability Services
- Multiple copies of documentation (i.e., faxed and mailed copies of a document)
- Staples, clips, binders, page protectors, folders, or similar items

Please note that submitting duplicate documentation and/or bound documentation may delay a decision regarding your request as all documentation must be processed.

DO SUBMIT:

- Legible copies
- All documents in English. You are responsible for providing certified English translations of foreign-language documentation
- Typed or printed letters and reports from evaluators
- Documentation from childhood if you are requesting accommodations based on a developmental disorder, i.e. LD, ADHD, Dyslexia
- Documentation of your functional impairment in activities beyond test-taking
- Documentation of your functional impairment beyond self-report

Mail your completed questionnaire and documents to:

Students / Graduates of US & Canadian Medical Schools
Testing Coordinator, Disability Services, National Board of Medical Examiners,
3750 Market Street, Philadelphia, PA 19104-3190.
215-590-9509

Students / Graduates of International Medical Schools
Test Accommodations Coordinator, Educational Commission for Foreign Medical Graduates
3624 Market Street, Philadelphia, PA 19104 USA.

Please keep a copy of your completed request form for your records.

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